WRITTEN STATEMENT
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JOINT
UNITED STATES DEPARTMENT OF JUSTICE
AND
FEDERAL TRADE COMMISSION
HEARINGS ON
HEALTH CARE COMPETITION LAW AND POLICY

HOSPITAL JOINT VENTURES AND JOINT OPERATING AGREEMENTS

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Background

A. I have been a senior level in-house counsel to managed care companies for the last 10 years. Since 1998, I have been employed by Oxford Health Plans as a member of its senior management team and its Chief Healthcare Counsel, and am currently a Senior Vice President. Oxford Health Plans covers approximately 1.6 million members, most of which reside in the New York City Metropolitan Area. Before joining Oxford, I was Vice President and General Counsel of Healthsource, Inc., a managed care company that covered more than 1 million people though health plans in 14 states and a nationwide insurance company. A principal part of my role for both Oxford and Healthsource has involved the negotiation and drafting of contracts with health care providers, including hospitals that have banded together under some sort of joint operating arrangement

B. Prior to becoming employed by managed care organizations, I was engaged in the private practice of law for 13 years, with the Washington, D.C. law firms: Epstein Becker & Green and Michaels & Wishner. My practice concentrated on health care and antitrust issues. Much of my private practice career involved representing managed care companies relating to regulatory issues for licensure and federal qualification. I also worked on regulatory and general health care issues for hospitals and other providers, especially during the two years that I spent in the San Francisco office of Epstein Becker. I worked on a number of antitrust issues. Most of my early antitrust work, in fact, focused on the antitrust implications of provider joint ventures formed to offer or contract with managed care plans. Subsequently, I also worked on other antitrust issues, including hospital and other mergers, as well as exclusions and terminations from hospital staffs and managed care networks. During my private practice years, I wrote, in collaboration with others, several antitrust pieces, including the antitrust chapters of the Aspen and Matthew Bender health law manuals.

C. I was a member of Member of New Hampshire Health Services Planning and Review Board (CON Board) for 3years, ending in 1992. During that time, collaborative proposals were presented to the board. In addition, I was involved in re-drafting the board's regulations including regulations relating to how collaboration among facilities would be considered in the context of reviewing competing applications.

D. The views I am presenting are not the views of Oxford Health Plans, but are my own.

Discussion

1. Hospital Joint Ventures and Joint Operating Agreements.

I have had the opportunity to interact with hospitals that have been parties to several different types of joint operating agreements, as their counsel, or as counsel to a managed care organization negotiating with the group, or as a regulator on the heath planning board. Some of these types of combinations appear to raise more competitive

concerns than others. In general, I believe that when the combination yields discrete, tangible community benefits, such as the creation of a new service, competitive concerns should be evaluated in light of the community and competitive benefit created by the combination – traditional joint venture analysis. However, when a combination does not create a tangible benefit, but rather the parties to it generally promise that the combination will enable them to achieve efficiencies, then I think that enforcement agencies need to be skeptical of the claims, review and challenge them carefully. There may be circumstances when tangible benefits can be demonstrated, and joint venture analysis is appropriate, but there will also be cases when per se treatment is appropriate.

Below I have set forth the types of hospital joint ventures and joint operating agreements I have encountered. I have arranged these beginning with those that, in my view, seem to raise the least amount of competitive concern to those that raise the most competitive concerns:

A. Joint Operation of a Service or Division.

Two hospitals enter into an agreement to share resources to offer a new service. This can be done either as some form of joint ownership, or as an agreement to share resources. For example, I am familiar with one situation in which two hospitals agreed to operate a new cancer treatment facility at one of the hospitals. The other hospital had its own cancer treatment facility, and historically had treated many patients from the primary service area of the other. The two hospitals shared certain scarce resources, principally physicians and physicists, needed to operate facilities in both locations.

In my experience this kind of arrangement presents itself to the public in one of two ways: either the "new service" operates sufficiently independently that it negotiates with payers itself or each facility negotiates separately with payers. There are competitive concerns, because the parties that are jointly operating the facility are competitors, but new capacity is created for the community.

B. Joint Operation of Two Financially Distressed or Weakened Hospitals

Two financially distressed hospitals in a region form an agreement to share costs and administration. The circumstance with which I am most familiar eventually led to a merger.

In my experience this kind of arrangement tends to present itself to the public as if it were a single entity. The weakness of the facilities may result in the relatively quick creation of a single management structure. There are competitive concerns, because the hospitals are competitors, but it is possible that an essential community resource is being preserved.

C. Operation of "Local Community Hospital" by Regional Hospital

A small community hospital enters into a management agreement with a regional hospital. The community hospital gains access to administrative and professional resources and expertise, as well as joint buying power. The community board of the managed hospital retains the ability to change directions if it doesn't work out.

I have seen this type of arrangement be presented to the public both as a "system" and as independent facilities. The competitive concerns here are perhaps not as significant as above, because the hospitals are likely not to be competing with respect to many services, but the community benefit is also not as clear.

D. Joint Operating Agreement Among Two or More Hospitals in the Same Geographic Region

Two or more hospitals in a community get together, form a common parent and undertake a few common activities. Common activities can involve purchasing and clinical cooperation. From my perspective as in house counsel to a managed care company, the key distinction is whether or not the hospitals negotiate with payers as a group. I am often not even aware of those groups that don't negotiate jointly.

The competitive concerns here are clear, once the hospitals have elected to negotiate jointly with payers. Whether this type of arrangement should be viewed as a joint venture, or whether one or more of their joint activities, including negotiations, should be viewed as separate instances of joint action, depends on the nature of the joint conduct.

2. Possible Benefits of Joint Operating Agreements.

A. Capacity.

1. Adding New Services/Capacity. Joint operating agreements, like other kinds of joint ventures, create a societal benefit when they involve the creation of a new service or asset in the community. In fact, the New Hampshire Health Services Planning and Review Board viewed this kind of collaboration as being sufficiently beneficial that the regulations require the Board to take this factor into account positively when evaluating competing applications to offer a particular service.

When a joint operating agreement results in the creation of new capacity, the legality of the arrangement should be considered under the traditional joint venture analysis. In this context, of course, ancillary restraints relating to the joint venture, as well as activities beyond the scope of the joint venture must be part of the analysis.

2. Preserving Essential Community Resources. Similarly, joint operating agreements that preserve essential community resources that would otherwise be lost also create a societal benefit. In New Hampshire, a key area of discussion has focused on emergency room access. While opponents of the certificate of need process have generally argued that competition will reduce costs and improve services, supporters

have voiced concern that, particularly in rural areas, displacement of traditional community hospitals by ambulatory surgical centers that do not have 24 hour emergency room capabilities will be harmful to the community.

When a joint operating agreement results in the preservation of an essential community resource, the legality of the arrangement should be considered under the traditional joint venture analysis. Of course, a threshold issue that is largely beyond the scope of this discussion is "what is an essential community" resource?

B. Clinical Integration/Clinical Pathways. Some joint operating agreements and virtual mergers reportedly involve clinical integration of the institutions. Sometimes, this includes development of practice guidelines or "clinical pathways" regarding the provision of certain services. It is possible that the joint efforts of the institutions can lead to improved quality of care, which could not be achieved by either institution on its own.

As a result, institutions engaged in joint operating agreements involving clinical integration regarding one or more specific services should be given the opportunity to demonstrate the specific efficiency or quality improvements they achieve as part of the antitrust analysis. If they cannot do so, then this joint conduct should be considered under Sherman Act Section 1 principles for restraints of trade. However, if the parties can demonstrate actual improvements in efficiencies or quality, then the joint conduct relating to clinical integration should be evaluated under a traditional joint venture analysis.

To undertake this analysis, it is important to understand what the term "clinical integration" means, and it may have a different meaning for different institutions. At least some of what hospitals mean by the term "clinical integration" is that they jointly research and establish standards and processes for the care of a particular type of condition, called clinical pathways, which each hospital may adopt and enforce on its own. The competitive implications of this type of activity is, in my view, no different than the competitive implications of other standards setting practices, such as the establishment of clinical practice guidelines by specialty medical associations, or the establishment of standards through the American National Standards Institute.

Clinical integration might, however, mean more than merely standards setting. Possibly, the term "clinical integration" also includes activities such as maintaining joint hospital staffs, and conducting some medical staff activities jointly. There could also be other circumstances in which two or more hospitals jointly produce a service, in a manner that would be considered to be a joint venture under the antitrust laws.

It is, perhaps, most important, with regard to this kind of arrangement, that close attention be paid to ancillary restraints. Specifically, the question is whether a group of facilities that has some form of clinical integration can engage in joint pricing of either the services around which they are integrating, or other services.

For example, standards setting activities like the development of clinical pathways should not, by themselves, support joint pricing for the services around which the pathways are developed. Certainly, manufacturers who work together to set standards for various products in connection with the American National Standards Institute, do not get the right to set prices for products produced that meet those standards.

In one circumstance of which I am personally aware, several hospitals located in one geographic area collectively negotiated rates with a managed care company, and apparently were advised that they were legally able to do so because they were engaged in joint clinical activities, including the development of clinical pathways for some services. The rates that they sought, however, were not limited to rates for the particular services for which they had developed clinical pathways. Instead, they sought an across the board percentage increase for all services at all of the hospitals in the group. My understanding is that this group has also negotiated prices jointly with other managed care plans in the area.

Here, the joint action of developing clinical pathways, like other standards setting activities, may (and probably does) have some societal benefit. However, the ancillary restraint, in this case, price setting, was not necessary or even really relevant to achieving the benefit. In essence, it was as if this group was saying: we have jointly developed a single project – a course of inpatient treatment for particular diagnoses – but the rate that we charge varies based on the facility where the product is produced. I think that would be fine, so long as the companies priced their products separately. However, in the case with which I'm familiar, what the group was really saying was: each hospital has its own product, and we all want the same percentage increase.

C. Efficiencies. Attorneys and economists representing hospitals have argued that joint operating agreements and virtual mergers can produce economic efficiencies that will be passed along to consumers in the form of lower costs. While there may be a theoretical basis to make such an argument, the practical and political difficulties of achieving efficiencies, suggest that these claims should be viewed with a great deal of skepticism. In many if not all virtual mergers, the management structures of all of the parties to the agreement remain in place. So this key area of cost savings in actual mergers does not apply in the context of a virtual merger. In addition, in many if not all virtual mergers, a new "management structure" is created, and new management level personnel are employed to administer the "parent" or joint venture. This would be an increased cost. In addition, the literature suggests that many virtual mergers allow the constituent parties with some level of veto power over operational changes. In such circumstances, it might be difficult even to achieve any efficiencies that would involve a service reduction at either facility.

As to whether efficiencies have been reflected in rates offered to managed care companies, I have never seen evidence that any cost reduction resulting from enhanced efficiencies have been passed along to the managed care company. In my experience, when hospitals enter into a virtual merger, two things happen: (a) rates stay in effect until the next contract expiration date and (b) rates increase at no less than common in the

market and usually more. I have never seen a rate reduction from a merged facility, and I have never seen a lower rate of increase requested from a merged facility. It is, of course, possible, that efficiencies are passed along to consumers in other ways, but I am not aware of this.

As a result of this experience over 10 years, I do not believe that generalized claims of efficiencies should be sufficient to support analyzing joint operating agreements as joint ventures, but rather that unless a joint operating agreement either adds a new capacity or preserves an existing capacity that would otherwise be lost, or otherwise creates some tangible benefit for the consumers, the agreement should be analyzed under Section 1 of the Sherman Act.

3. Possible Competitive Harm of Joint Operating Agreements.

A. Systems Can (and Do) Require Contracts with All Members.

Each and every time that I have represented a managed care company in contract negotiations with any hospital system, the system has insisted that we contract with all members of the system. This limits the managed care organization's ability to select the hospitals with which it desires to contract. Moreover, when the systems' hospitals are competitors, this also limits the ability of the managed care organization to obtain better rates from one hospital by steering business to a hospital, by excluding its competitor.

In my experience, most of the time, the managed care organization has also been interested in contracting with all of the hospitals in the system, too. Oxford, historically, has contracted with most or all of the hospitals in our service area. However, we were able to negotiate different deals with each hospital, and we had a choice as to whether to maintain a contract. As more and more hospitals become part of systems, we see uniform contracts, many of which include some of the problematic provisions set forth below.

B. Systems Can (and Do) Stifle New Competitive Entrants.

1. Service "Carve Outs"

Historically, one way managed care companies were able to address cost issues was to develop limited networks for certain services. These are known as "carve out" services, and the companies that have grown up to specialize in the delivery of these services are known as "carve out" companies. Oxford does not "carve out" many services, although we do use a pharmaceutical management company to deliver pharmacy services, and also work with companies that assist us in managing physical therapy, chiropractic care, and diagnostic imaging. Other examples of carve out companies include mental health management companies.

As systems have gained market power, they have increasingly demanded, as a condition of contracting, that they be allowed to participate for all services, even for services for which they are paid grossly over the market. For example, it is not too hard

to find laboratory services companies that will contract to provide services at less than the price the Medicare program pays. Hospitals often charge at least 150% of Medicare for these services. The erosion of the health plan industry's ability to "carve out" services is a factor in increasing rates seen by consumers.

2. Global Risk Arrangements

Similarly, some hospitals have been willing to enter into arrangements with managed care companies under which the hospitals shares risk with the MCO on the cost of providing care to a population of members. This has been particularly prevalent in Medicare contracting. One key to the success of these deals has been the volume of business that goes to providers who are not participating in the risk sharing arrangement. In many cases, particularly in Medicare HMO programs, the ability of a Member to obtain services from providers who are not participating in the risk arrangement can be constrained by excluding those providers from the network available to the Member. Generally, in an HMO plan, a member cannot obtain covered services from providers who are excluded from the network, except in cases of emergency or in cases when no network provider is capable of providing the service. When systems are able to negotiate "no carve out" provisions, they can essentially alter the economics of global risk arrangements by forcing the managed care organization and the risk assuming provider network to accept a higher level of leakage. Greater leakage can make some global risk arrangements economically unfeasible. If this results in providers terminating existing risk arrangements, or refusing to enter into them, there will be an adverse impact on the Medicare HMO program.

C. Increased Market Share Can Lead to Increased Rates

Over the last three years, Oxford has seen requests for rate increases from hospitals of as much as 60% year over year. Many of the requests for extremely large rate increases have come from systems, some fully merged, and some operating under virtual mergers, or joint operating agreements. Admittedly, a number of the hospitals in our primary market have had financial problems. Not all rate increases can be attributed to joint conduct, and we have largely been successful at negotiating more reasonable rate increases.

We believe, however, that the combination of hospitals has resulted in increased rates, which we must pass along to consumers. Rate increases have been particularly high in the areas where systems are most dominant, or where hospitals have monopoly power.

4. Sharing Profits and Losses as Proof of "Unitary" Enterprise

More than 20 years ago, in an amicus brief written on behalf of the American Association of Foundations for Medical Care, the organization that became American Association of Health Plans, in the case of Arizona v. Maricopa County Medical Society, Bill Kopit and I argued that maximum price fixing should be not analyzed under the per

se rules of illegality. We lost that argument (although in a more recent case, the Supreme Court ultimately agreed with our position) but we were able to persuade the court that joint ventures of providers that shared profits and losses should be analyzed as joint ventures.

Some attorneys have argued that, under the dicta in this Supreme Court ruling, any sharing of profits and losses is an indicator of a unitary entity, regardless of whether profit and loss sharing is around a jointly created and operated "product." What the court was talking about in the Maricopa County case was whether providers could jointly offer an HMO product in which they set the prices charged to their joint venture HMO. But when the arrangement does not involve sharing risk around a particular product or service that is jointly produced, then the arrangement is not really evidence of a "unitary" enterprise.

In fact, absent creation of some "product" or "venture," agreements to share profits and losses could, in fact, be evidence of cartel behavior. In essence, what this kind of agreement recognizes is that price fixing might not benefit all conspirators equally. The parties to the price fixing agreement may have different costs and the jointly negotiated price might not produce a profit for all of them. So an agreement among conspirators to "spread the wealth" would assure that all parties get at least some benefit from the agreement. As a result, an agreement to share profits and losses can be a means to encourage adherence to a price fixing agreement. So, in circumstances when there is no new product or capacity created, or no clear benefit to consumers, the mere existence of a profit and loss sharing agreement should not support a rule of reason or joint venture analysis.

5. **Enforcement.**

It is important for the enforcement agencies to reinforce the historical "bright line" rules that the courts have drawn, and to apply these rules consistently to the health care industry. As the courts recognized when they created per se rules, rule of reason analysis is difficult, time consuming and costly. The result is that, once rule of reason analysis applies, both private and public enforcement actions are less likely to occur. In fact, as you are no doubt aware, public and private enforcement actions are less likely to take place when there is even a plausible claim for rule of reason treatment. Ambiguity in this regard reduces the sentinel effect of enforcement actions and encourages the development of new "joint arrangements" and ancillary restraints that have little societal benefit, but do raise prices.

Recent experience suggests that one enforcement tool could be to require joint ventures, including virtual mergers to dissolve. It appears that this can be done when the facilities remain intact, and when management structures exist, or can be created, to operate both facilities. In New York, for example, the arrangement between Mt. Sinai Hospital and the New York University hospitals recently dissolved. In Manchester, New Hampshire, a true merger between the two local hospitals was also recently undone.

Conclusion

Rising health care costs create many problems, including greater labor costs for employers, and a higher level of uninsured individuals. Some of the increases are unavoidable, and some joint ventures among hospitals create important benefits for consumers that should be preserved. However, the enforcement agencies should take measures to restrain the growth of unnecessary and avoidable cost increases, some of which I believe result from inappropriate combinations of health care providers.